LOCAL TOBACCO CONTROL COALITIONS IN THE UNITED STATES AND CANADA: CONTAGION ACROSS THE BORDER?

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**This work was completed, in part, while SJ Frisbee was a doctoral student in the Department of Political Science, West Virginia University Eberly College of Arts and Sciences (DTS, Advisor and Committee Chair)*

Presented at:
11th Annual Conference of the Canadian Political Science Association
May 16-18, 2011, Wilfrid Laurier University, Waterloo, ON

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ABSTRACT

As efforts to enact tobacco control policy have evolved, so have the institutional arrangements supporting and promulgating these efforts. In the United States, the CDC has adopted as its 'best practice' networks of community-based advocacy coalitions as the platform for prevention and policy advancement efforts. This arrangement, which progressed after the COMMITT, ASSIST, and Smokeless States trials, is implicitly consistent with a bottom-up approach to tobacco policy advocacy and adoption. In the United States, this network of coalitions is funded by both public and private sources. While some research has begun to emerge on the nature and structure of these coalitions, institutional arrangements and the institutionalizations of coalitions nevertheless remain one of the lesser-explored but important dimensions of tobacco control policy in the United States as an influence of on state policy and even central policy (Studlar 2002; Shipan and Volden 2007). Although these local tobacco control coalitions were slower to develop in Canada, Canada did participate in the COMMITT study and funding by the central government since the mid 1990s has enabled their establishment and continuing consultative roles at the provincial and federal levels. The question arises as to the similarities and differences between these coalitions and institutional arrangements between Canada and the United States. This paper examines this question in terms of the funding and organizational characteristics of these institutions, the process through which they attempt to influence tobacco control policy at the provincial and federal levels, and the tobacco-related health outcomes in their jurisdictions. How much have the Canadian organizations borrowed from their counterparts in the U.S., or vice versa, in structure, and have the processes and outcomes been similar? What do the findings tell us about the possibilities of lesson drawing on various levels across borders in dealing with common global health problems?

INTRODUCTION

Tobacco products remain among the most controversial consumer products of all time. As many others have previously highlighted, cigarettes are the only legal product that, when used as intended, are lethal. Alternately stated, there is no safe level of exposure to tobacco, tobacco smoke, or tobacco smoke particles. (U.S. Department of Health and Human Services, Office of the Surgeon General, 2006) Further, the global and individual burden attributable to the primary use of tobacco, or secondary or tertiary exposure to cigarette smoke, whether measured by morbidity, mortality, or economic costs, is substantial. Smoking has been causally linked to multiple cancers, coronary heart disease, stroke, obstructive lung diseases, infertility, and Sudden Infant Death Syndrome (SIDS). (Centers for Disease Control and Prevention, 2009) Exposure to secondhand smoke, also called "passive smoking" or environmental tobacco smoke, is causally linked to heart disease and cancer, and, in children, ear infections, exacerbation of asthma and other respiratory symptoms and infections, and increased risk for SIDS. (Centers for Disease Control and Prevention, 2010) Additionally, recent reports have documented that residual tobacco smoke on surfaces, including clothing, furniture, vehicle surfaces, and skin, reacts with ambient nitrous acid to form carcinogenic substances, resulting in yet another exposure route, a "third-hand" route, to the deleterious effects of tobacco products. (Sleiman, Gundel, Pankow, Jacob, Singer, & Destaillats, 2010) In the United States, it is estimated that each pack of cigarettes sold represents a $10.47 loss in direct (medical care) and indirect (productivity) costs and that there are 5.1 million years of potential life lost annually due to cigarette smoking. (Centers for Disease Control and Prevention, 2009) From 2000-2004, the total economic losses in the United States attributable to cigarette smoking were $193 billion ($96 billion direct medical expenses, and $97 billion in indirect lost productivity). (Centers for Disease Control and Prevention, 2009) Further, annual mortality in the United States attributable to smoking is estimated at 443,000, including almost 50,000 deaths annually from secondhand smoke. (Centers for Disease Control and Prevention, 2009) Globally, the World Health Organization estimates that tobacco causes 5 million deaths annually and, by 2030, the annual tobacco-attributable mortality will climb to 8 million annually, resulting in one billion cumulative deaths in the 21st century. (World Health Organization, 2008) More notably, of the 1.1 billion people worldwide who currently smoke, 80% live in low- and middle-income countries and these same low- and middle-income countries are projected to experience more than 70% of the predicted one billion 21st century cigarette-related deaths. (Jha, Avoidable global cancer deaths and total deaths from smoking, 2009) Thus, tobacco is amongst the leaders in global all-cause mortality, is most assuredly the leading cause of preventable death (World Health Organization, 2008), and is increasingly a barrier to overcoming health disparities both within and between countries.

The nature and magnitude of the adverse health, economic, and societal effects of tobacco have emerged through the efforts of almost a century of scientific research. Combined with the efforts of public health and policy advocates, the image and use of tobacco products has undergone profound change. Starting with the Agricultural Adjustment Act of 1933, the U.S. government (Department of Agriculture) provided price supports for tobacco farmers in exchange for agreed-upon acreage and production quotas. Further, in a practice that started in World War I and continued until the 1975, the U.S. military distributed cigarettes as part of rations for military personnel (formal military

tobacco control efforts did not begin until 1986). (Smith & Malone, "Everywhere the soldier will be": wartime tobacco promotion in the US military, 2009) Thus, in the 1950s tobacco in general and cigarettes specifically were widely used and accepted products, promoted and endorsed by physicians and the government alike. However, there has been a monumental paradigm shift in the perception, regulation, and use of these products in the last half century such that these products have become marginalized, if not de-normalized. While comparative data prior to 1960 are difficult to obtain, there has been substantial decline in smoking prevalence in OECD countries since the middle of the 20th century. Whereas in many countries half or almost half of their population were daily smokers in 1960, by the start of the 21st century the vast majority of OECD countries had halved that – i.e., ≤25% of the total population were daily smokers – and the prevalence of daily smokers continues to decline. Further, though also with the caveat that comparative or standardized data are not readily available, surveys from the Gallup., Inc.® have reported that in 1999, 92% of Americans believed that smoking caused lung cancer (Morales, L; Gallup, Inc., 2008), that 56% of adults in 2008 thought that secondhand smoke was harmful compared to 36% in 1995 (Morales, L; Gallup, Inc., 2008), and that 54% of adults in 2005 supported smoking bans in restaurants compared to 17% in 1987. (Moore, D W; Gallup, Inc., 2005). Further still, the United States has developed and implemented what is regarded as one of the most restrictive tobacco control policy regimes in the world today. (Studlar, What explains the paradox of tobacco control policy under federalism in the U.S. and Canada? Comparative federalism theory vs. multi-level governance, 2010)

This paradigm shift in attitudes, behavior, and policy has been achieved through multi-disciplinary efforts sustained over multiple generations: physiologists and pathologists, epidemiologists, health economists, public health scientists, sociologists, and political scientists. However, while much has been accomplished to change both policy and behavior, much remains to yet be accomplished, both within developed countries including the United States, and globally. The fact remains that, despite decades of effort and advocacy, tobacco use continues to place an enormous burden on societies. The most recent estimates from the CDC attest to this: 46.6 million Americans are current smokers and an additional 88 million, including 54% of children 3-11 years of age, are exposed to secondhand smoke; and there continue to be approximately 443,000 tobacco-attributable deaths and 8.6 million tobacco-related illnesses annually. (Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010) Additionally, estimates have suggested that smoking-attributable expenses averaged 11% of state Medicaid expenditures, or a total of $22 billion nationwide, in 2004 (Armour, Finkelstein, & Fielbelkorn, State-level Medicaid expenditures attributable to smoking, 2009), and that between 1995–2015 tobacco-related Medicare expenses will be $800 billion. (Department of Health and Human Serivces, Centers for Medicaid and Medicare Services, 2010) Further, there is considerable evidence that tobacco use is becoming highly concentrated in lower socio-economic groups (smoking prevalence is approximately 25% in those with a high school education or less, or 50% of all current smokers, compared to 6% in those with a graduate degree), and that the rate of decline in smoking is slowing (the smoking prevalence in the U.S. was estimated at 20.9% in 2005 and 20.6% in 2009; in high school students, between 1999-2003 smoking prevalence declined from 36% to 22%, but between 2003-2009 declined from 22% to 20%), both of which are disquieting trends. (Centers for Disease Control and Prevention, National Center for Chronic Disease

Prevention and Health Promotion, Office on Smoking and Health, 2010) Stated more starkly, it is likely that the next 10% of smoking prevalence will be more difficult and intransigent to eliminate than the previous 10% of population smoking prevalence as tobacco use becomes socially and politically entrenched in socioeconomic and geo-demographic clusters that are traditionally more difficult to reach and less responsive to conventional health promotion and health education messages and public health policy arguments. That is, counter-acting the decline in the gains from public health advocacy and policy change efforts will require an increase in the efficiency of these efforts – not necessarily of the endorsed programmatic or policy solutions themselves, but of the efforts to enact these evidence-based programs and policies. Thus, increasing the efficiency of these programmatic and policy enactment efforts will implicitly require a much clearer and more precise understanding of the factors that will facilitate (or impede) a given jurisdiction in the adoption of strategies to reduce smoking prevalence and consumption, including the implementation of comprehensive tobacco control policies.

The historical role and importance of scientific information and experts in influencing the social changes in both tobacco use and development and adoption of comprehensive tobacco control policy is not in dispute. Conceptually, the impact of this information in changing the fundamental understanding of the problem, including the construction of risk and victimization, the policy images, the perceptions of the tobacco industry, the social changes that this information fueled, and the scientific evidence for the effectiveness of policy instruments has been well discussed both within the United States and globally. (Nathanson, Social movements as catalysts for policy change: the case of smoking and guns, 1999), (Nathanson, The contingent power of experts: public health policy in the United States, Britain, and France, 2007), (Asbridge, 2004), (Beaglehole, 1991), (Warner, The role of research in international tobacco control, 2005), (Bayer & Colgrove, Science, politics, and ideology in the campaign against environmental tobacco smoke, 2002), (Mamudu, Epistemic Communities and Global Tobacco Control Policy Making, 2007) However, what has been less well understood, particularly within the public health community, is why, despite overwhelming scientific evidence, comprehensive tobacco control policy adoption has not followed logically and rationally from this overwhelming scientific evidence. While some within the public health and epidemiologic communities have attempted to better understand – and modify – the effectiveness of the application of science to public policy, (Savitz, Poole, & Miller, Reassessing the role of epidemiology in public health, 1999), (Brownson, Royer, Ewing, & McBride, 2006), (Brownson, Chriqui, & Stamatakis, Understanding evidence-based public health policy, 2009) a substantial proportion of the tobacco control advocacy community has and continues to respond with disbelief and frustration, viewing a "failure" to adopt the "right" or "needed" policy as a "failure" of the political system. (Larsen, The political impact of science: is tobacco control science- or policy-driven, 2008)

However, the interpretation of the failure to adopt tobacco control policies is much more complex than a "failure" of the political system. As has been previously observed,

> "The path from knowledge to policy is not straightforward; scientific consensus does not lead automatically to policy consensus."

> *From:* (Nathanson, The contingent power of experts: public health policy in the United States, Britain, and France, 2007)

That is, the adoption of comprehensive tobacco control policy is a function not only of factors influencing the intersection between scientific and epistemic communities and policy, but also of social factors influencing the willingness of the populace in a jurisdiction to accept such policies, as well as the factors directly influencing the functioning of the policy subsystem and the representation of interests within it, as suggested by the Advocacy Coalition Framework. (Sabatier & Jenkins-Smith, 1999), (Sabatier & Weible, 2007) The ability to more precisely understand and thus develop an accurate, predictive model of tobacco control policy adoption is complicated by the interrelationship between the two outcomes of interest: tobacco use (outcome of prevalence) and tobacco control policy (outcome of policy adoption). This interrelationship has been discussed conceptually,

> "Factors other than government policy – especially shifts in social norms – have influenced that decline, but those norms have themselves been directly and indirectly influenced by government policies. In short, tobacco consumption has become, in part, a political outcome….These respective tobacco-control regimes emerge as largely consistent with broader public attitudes about the importance of health and "well-being," but we have less confidence about whether such attitudes influence the development of control legislation, or if the direction of causation is reversed."
>
> *From:* (Marmor & Lieberman, 2004)

Thus, the three broad spheres influencing the evolution of tobacco use and tobacco control policy are scientific, social, and political and the two primary outcomes of interest – tobacco use (smoking prevalence) and tobacco control policy adoption (the tobacco policy regime or comprehensive tobacco control policy) are interdependent with feedback mechanisms more accurately characterized by a causal loop.

In combating the tobacco epidemic, then, public health and policy advocates have faced both conceptual and technical challenges in attempting to increase the comprehensiveness of tobacco control polices and reduce the public health burden of tobacco use, importantly including reductions in smoking initiation and prevalence. A common, and now almost ubiquitous, strategy within these communities has been the advancement of a "coalition" format to address tobacco use and tobacco control policy. While implicitly consistent with a bottom-up approach to tobacco policy advocacy and adoption, a coalition strategy may also better facilitate the ability to simultaneously address each of the "three spheres" of the tobacco control challenge – scientific, social, and political – particularly in a diverse polity. However, while this "coalition strategy" is now widespread, relatively little is understood about how different coalitions in different jurisdictions are structured or how they evolved, their activities or strategies, or how any of these (structures, activities, strategies) have impacted the "three spheres" of the tobacco control challenge: scientific (disseminating scientific "truths", dispelling scientific "myths", and bringing this knowledge to bear on tobacco use and

policy), social (denormalisation of tobacco use), and political (the representation of public health interests in policy subsystems), or the important outcomes of interest (comprehensive tobacco control policy implementation and reduction in tobacco use and burden). While an all-encompassing investigation of structure, function, and comparative effectiveness of these "coalitions systems" is beyond the scope of a single work, the purpose of the present study is to compare the structures of tobacco coalition systems in Canada and the United States and how they evolved, with discussion about how these systems may have impacted the dual outcomes of tobacco control policy and tobacco burden in the two countries. The current investigation begins with a discussion of the general evolution of the tobacco epidemic in developed countries.

BACKGROUND: THE EVOLUTION OF THE TOBACCO EPIDEMIC IN DEVELOPED COUNTRIES

The tobacco epidemic in the industrialized world has evolved over the last 60+ years, during which time tobacco evolved from a widely used and little regulated product to one that is now used by less than a quarter of the American population and is highly regulated. It is not surprising, then, that models developed to characterize the tobacco epidemic have developed stages based on chronologic demarcations in public health parameters and policy approaches. Two models based on the historic evolution of the tobacco epidemic in the United States and other industrialized countries, the Phases of Tobacco Control model and the Tobacco Epidemic Model, are described below.

The Phases of Tobacco Control Model

The Phases of Tobacco Control is a six-stage model that demarcates the tobacco epidemic based on the type of tobacco control policy regime. (Studlar, Tobacco Control. Comparative Politics in the United States and Canada, 2002), (Studlar, U.S. tobacco control policy: public health, political economy, or morality policy?, 2008) The six phases are outlined in Table 1.

In Phase I, cigarettes in particular evolved rapidly from a niche product to a much more widely used consumer product due to the development of the automatic cigarette making machine and its subsequent widespread use by James B. Duke, the portable safety match, reliable packaging, and extensive advertising. The U.S. federal government did not pursue any restrictive policies, rather deferring action, if any, to the states. Tobacco products were the target of some temperance movements and some states enacted product bans, though most states did not implement any restrictive policies.

Table 1. Phases of Tobacco Control Model

Phase	Timeframe	Title/Description
Phase I	1884-1914	Consolodation of the Cigarette Industry and Early Controversies
Phase II	1914-1950	Era of Good Feeling; Cigarettes Promoted by Governments
Phase III	1950-1964	The Gathering Storm of Health Concerns
Phase IV	1964-1984	Regulatory Hesitancy
Phase V	1984-2008	Tobacco as Social Menace
Phase VI	The Future	Neoprohibitionism versus harm reduction?

Source: (Studlar, U.S. tobacco control policy: public health, political economy, or morality policy?, 2008)

The second phase, encompassing both World Wars, marked a substantial expansion in the use of cigarettes. Cigarettes were regarded as the lesser of three moral sins available to troops (the other two being alcohol and prostitution) and so their use was promoted by the government. Thus, cigarettes acquired a *de facto* image of being patriotic and socially acceptable.

In the third phase, credible scientific evidence began to emerge that raised concern about deleterious health effects, particularly lung cancer. Some popular media outlets began to cover these stories and additional research was supported by private organizations such as the American Cancer Society. Despite the mounting evidence however, government policy remained lax, with few restrictions and some, but not substantial, taxation.

In the fourth phase, a series of government-sponsored reports were published from multiple countries, including the United Kingdom and Canada, and culminated in the 1964 U.S. Surgeon General's Report. (U.S. Department of Health, Education, and Welfare, 1964) These reports served to review the scientific evidence linking tobacco to adverse health outcomes and then to affirm and endorse that tobacco caused various diseases and even mortality. Thus, while the tobacco industry could discredit and so deflect the conclusions of individual studies, this task became much more difficult when it was the position of multiple governments that the cumulative evidence supported that tobacco caused cancer, among other diseases (though this did not deter them from so trying). Despite these now-endorsed scientifically-based positions, government policy to reduce tobacco consumption and smoking prevalence remained largely impotent. While some package labeling requirements were enacted, lax federal taxation policies (which were not increased between 1951 and 1982) resulted in cigarettes becoming more affordable over time. It was not until the early 1980s and the publication of several exposé-type books and articles in the popular media that the course in both public opinion and policy finally began to change.

In the fifth phase, scientific evidence regarding the health hazards of secondhand smoke as well as the addictiveness of nicotine changed the tone of the public and policy discourse. More, increasingly restrictive tobacco control policies were enacted and social attitudes toward both smoking and the tobacco industry became increasingly negative. This phase also saw multiple, additional Surgeon General's reports, increased legal activity directed against tobacco companies, including that by the state Attorneys General, and the Master Settlement Agreement.

The sixth and final phase, with yet to be determined activities and results, foreshadows the looming challenge for tobacco control activists pursuant to alternate and so called "reduced risk" tobacco products, products that tobacco companies are increasingly developing as smoking prevalence (and industry revenues) in industrialized countries continue to decline.

The Tobacco Epidemic Model

The Tobacco Epidemic Model was proposed based on the study of the historic patterns in five key metrics of the tobacco epidemic (smoking prevalence, cigarette consumption, lung cancer rates, smoking attributable death, and tobacco control activities) in industrialized countries such as the United States, Canada, and the United Kingdom. (Lopez,

Collishaw, & Piha, 1994) The characteristics of each stage of the Tobacco Epidemic model, based on these five metrics, are described in Table 2.

In Stage I, male and female smoking prevalence starts at very low levels but begins to rise rapidly though few, if any, tobacco related deaths are evident. In Stage II, male smoking prevalence rises rapidly and reaches levels far higher than that for females, reaching as high as 50%-80% of the male population. By the end of this stage, tobacco-attributable illness and deaths rise rapidly, accounting for 10% of all male deaths. Tobacco control activities in this stage are poorly developed, if present at all, and cessation and cessation support activities are uncommon. In Stage III, the prevalence of male smoking peaks and then begins to decline. The prevalence of female smoking plateaus later in this stage and then also begins to decline, though smoking prevalence among younger women can reach levels close to that of males. Knowledge of smoking health hazards becomes more widespread, yet because of the latency between exposure and tobacco-related illness and death, during this stage the incidence and prevalence of tobacco-attributable disease continues to rise rapidly and peaks at 25%-30% of male mortality, with tobacco-proportionate mortality even higher in the middle-age groups. However, as knowledge of smoking hazards spreads, the receptivity for tobacco control increases and such activities become more organized and successful, and tobacco control policies become more comprehensive. In Stage IV, the final stage of this epidemic model, smoking prevalence for both genders continues to decline at slow but similar rates, but smoking-attributable death rates remain high – 30%-35% of all female deaths and 40%-45% of male deaths in middle age. While smoking-attributable male death rates begin to decline at the latter

Table 2. The Tobacco Epidemic Model

	Stage I	Stage II	Stage III	Stage IV
General Characterization	The beginning	Expansion to widespread use	Beginning of both abatement and the "real" health consequences	Decline and denormalization
Prevalence (Male)	Low (<15%) in early stage but rising rapidly in atter stage	May reach 50%-80%	Peaks in early stage (often at ≈60%) then declines in latter stage to ≈40%	Continues to decline, though slowly
Prevalence (Female)	Very low due to traditional socio-cultural factors (<5%-10%)	Lags male prevalence, but rises rapidly	Peaks in mid-stage (often at ≈35%-45%) and then decreases to a period of long plateau; distribution of female smoking typically highly skewed,with much higher prevalence in younger women (often ≈40%-50%) but much lower in older women (often <10%)	Continues to decline, though slowly
Consumption	Low (<500 cigs/person/year)	1000-3000 cigs/person/year	3000-4000 cigs/person/year in males and 1000-2000 cigs/person/year in females	Not specified
Lung Cancer Rate (Male)	Rare	Rapid rise from 5/100,000 to 50/100,000	Peak in latter stage at ≈110-120/100,000	Rates decline, possibly as much as 20% from their peak
Lung Cancer Rate (Female)	Rare	≈8-10/100,000	25-30/100,000	Not specified
Smoking Mortality (Male)	Not yet evident in early stage, but a few cases emerging toward the latter stage	By latter stage, ≈10% of all-cause mortality is attributable to smoking	Rapid rise to latter stage when 25%-30% of all-cause mortality is attributable to smoking	Peaks early in stage often at ≈30%-35% of all-cause mortality, then progressively declines
Smoking Mortality (Female)	Not yet evident	Still very low	Low but rising to latter stage when ≈5% of all-cause mortality is attributable to smoking	Rises rapidly during this stage, though its eventual peak depends upon the peak in female smoking prevalence; 2-3 decades into stage the eventual peak could reach ≈20%-25% of all-cause mortality then begin to decline
Policy	No control policies; agricultural support policies likely	Control activities sporadic and not well developed; lack of public and political support in part due to yet poorly understood risks	Conditions for control policies become more favorable; smoke free public places and transportation are among the first enacted but smoke-free workplaces not yet common; media important in enacting policies; smoking is becoming socially not as acceptable	Increased "demand" for legislation that provides for smoke-free personal environments; policies needed to support nicotine-addicted smokers who want to quit; social differences in smoking prevalence persist; continued changes in social climate need to be supported
Duration	≈20 years	≈20-30 years	≈20-30 years	20+ years

Source: (Lopez, Collishaw, & Piha, 1994)

phases of this stage, smoking-attributable female death rates continue to rise, reflective of female smoking prevalence peaking after that for males. An important focus of tobacco control activities becomes ensuring smoke-free environments, including smoke-free workplaces. Likewise, smoking cessation efforts expand, though socio-economic differences in smoking prevalence and smoking-attributable death continue.

Both the Phases of Tobacco Control and the Tobacco Epidemic Model are natural history models based on the unfolding of the tobacco epidemic in the United States and Canada (the former model, which, since its original introduction, has been updated to include most industrialized democracies – see (Studlar, The political dynamics of tobacco control in Australia and New Zealand: explaining policy problems, instruments, and patterns of adoption, 2005), (Studlar, Tobacco Control Policy in Western Europe: A Case of Protracted Paradigm Change, 2009)) and, more broadly, industrialized countries that included the United States and Canada (the latter model). While the models have a slightly different emphasis as the basis for differentiating between the different phases of the epidemic, both models span the 100+ years over which the tobacco epidemic has unfolded in industrialized countries. Additionally, both models have in common that tobacco control activities do not begin in earnest for at least 75 years after the beginning of the epidemic, a time after which male smoking prevalence in particular has already peaked, often at more than half of the male population, and thus when the consequences of decades of expanding and unchecked smoking and subsequent lung cancer and other morbidities and smoking-attributable mortality are first being felt. That is, while individual coalitions may have been started, their effects – tobacco control policy adoption or reductions in smoking prevalence – were realized too late to avoid the substantial individual and societal costs attributable to tobacco use. The importance of a better understanding of the relative effectiveness of the different aspects of these coalition systems thus becomes apparent: evading avoidable costs in an epidemic with a substantial social-behavioral component (i.e., a chronic disease, in contrast to a classic contagious or communicable disease, epidemic) is contingent upon earlier enactment of policies and changes in population behavior to shorten the duration of the epidemic stages or avoid them altogether, whether the challenge is tobacco or other diseases such as diabetes.

TOBACCO COALITIONS IN THE UNITED STATES

The series of government-sponsored reports were published from multiple countries, including the United Kingdom and Canada and culminating in the 1964 U.S. Surgeon General's Report. (U.S. Department of Health, Education, and Welfare, 1964) provided the impetus for the formation of myriad anti-smoking groups: to fight the new health problem, namely tobacco use. Groups opposing the tobacco industry have evolved substantially over time in number, focus, resources, and organization, the result of significant legal mobilization and social mobilization of interests efforts. What began as a few groups that formed in response to the mounting scientific evidence of the deleterious health effects and substantial (and avoidable) societal costs caused by tobacco products, has evolved (expansion) into a series of organizations and bureaucracies that support a (now) fairly extensive and overlapping network of coalitions. While it is beyond the scope of the present analysis to provide a detailed account of evolution of each these groups and networks, a broad overview and timeline is shown in Table 3. The development of these groups can be viewed as having

Table 3. Overview of the Development of Anti-Tobacco Groups and Coalitions

Era	Year	Event
Grassroots / State Coalition Movement (1960s-1980s)	1963	• Colorado state coalition forms
	1965	• CDC establishes the National Clearinghouse for Smoking and Health
		• National Clearinghouse later becomes the Office on Smoking and Health
	1967	• Action on Smoking and Health is formed
	1970s	• GASP (Group Against Smoking Pollution) networks form nationwide
National Movement (1980s-2000s)	1981	• Coalition on Smoking or Health forms (includes American Lung Association, American Cancer Society, and the American Heart Association)
	1986	• American's for Non-Smoker's Rights (ANR) is established
	1985-1993	• National Cancer Institute funds the COMMIT (Community Intervention Trial for Smoking Cessation)
Era of Coalition Funding (1990s – Present)	1991-1998	• National Cancer Institute and American Cancer Society fund ASSIST (American Stop Smoking Intervention Study for Cancer Prevention) trial
		• ASSIST is supplemented by the IMPACT (Initiative to Mobilize for the Prevention and Control of Tobacco Use) trial by the CDC
		• ASSIST and IMPACT trials later become incorporated into CDC's National Tobacco Control Program
	1994-2000	• Robert Wood Johnson Foundation in conjunction with the American Medical Association fund the Smokeless States initiative
	1995	• Robert Wood Johnson Foundation launches the Center for Tobacco Free Kids
		• This Center plays an important role in the negotiations leading up to the Master Settlement Agreement
	1998	• American Legacy Foundation is created by and funded from the Master Settlement Agreement
	1999	• National Tobacco Control Program is launched at the CDC
	1999	• The CDC, Office on Smoking and Health, National Tobacco control Program publishes the first "Best Practices for Comprehensive Tobacco Control Programs"
	2007	• The CDC, Office on Smoking and Health, National Tobacco control Program publishes and updated "Best Practices for Comprehensive Tobacco Control Programs"

Source (in part): (Centers for Disease Control and Prevention, 2007)

occurred in three phases: a phase of "grass-roots" or state- and local-level groups, a phase of formation of national-level advocacy groups, and an institutionalization phase. Additionally, the types of groups formed in each of the phases are mix of private and public.

Within the U.S., national efforts, even if initially limited to coordination and information dissemination, began early. The National Interagency Council on Smoking and Health (N.I.C.S.H.) was formed by 1965 and was "a voluntary association of national agencies and associations to combat smoking as a health hazard" with a key objective to "serve as a medium for exchange for groups and organizations concerned with the smoking problem". (Foote; Foote, E; for the National Interagency Council on Smoking and Health, 1965) Other national efforts developed and evolved, particularly private ones, and in 1981 the N.I.C.S.H. began a process, in conjunction with the American Cancer Society, the American Heart Association and the American Lung Association, that eventually led to the national Coalition on Smoking or Health (C.O.S.H.) to better coordinate and cooperate on the activities of the different groups; John Kessler (not to be confused with Dr. David Kessler) was the initial Chair of the Steering Committee for C.O.S.H. and Matthew Myers the Staff Director (later of the Coalition for Tobacco Free Kids). (Coalition on Smoking or Health)

The C.D.C., the nation's leading public health agency, was established very early as a "hub" for tobacco control activities, including the development of "best practices" and the synthesis and dissemination of credible scientific and technical information to support groups and organizations in the promotion of the adoption of anti-tobacco polices. The National Clearinghouse for Smoking and Health was established in what is now the Office on Smoking and Health at the C.D.C. in 1965. Further, the C.D.C., in collaboration and conjunction with other governmental (e.g., the National Cancer Institute, an institute within the National Institutes of Health in the U.S. Department of Health and Human Services) and non-governmental, health-focused organizations (e.g., the Robert Wood Johnson Foundation and the American Cancer Society), had and active scientific research agenda, developing and funding grants and programs to establish the

evidence for "best practices" and "evidence-based policy". The four most widely-known programs were the COMMIT and ASSIST trials, and the IMPACT and SmokeLess States programs:

- **COMMIT** (Community Intervention Trial for Smoking Cessation)
  - Funded by the National Cancer Institute of the National Institutes of Health as a competitive demonstration project
  - Focused on heavy smokers
  - Ended in 1992
  - Participating communities: Vallejo, CA , Hayward, CA, Cedar Rapids/Marion, IA, Davenport, IA, Fitchburg/Leominster, MA, Lowell, MA, Paterson, NJ, Trenton, NJ, Santa Fe, NM, Las Cruces, NM, Yonkers, NY, New Rochelle, NY, Utica, NY, Binghamton/Johnson City, NY, Raleigh, NC, Greensboro, NC, Medford/Ashland, OR, Albany/Corvallis, OR, Bellingham, WA, Longview/Kelso, WA, Brantford, Ontario, Canada, Peterborough, Ontario, Canada
- **ASSIST** (American Stop Smoking Intervention Study)
  - Funded by the National Cancer Institute of the National Institutes of Health as a competitive demonstration project
  - Planning phase (October 1991 – October 1993) and implementation phase (November 1993 – September 1999)
  - 17 participating states (Colorado, Indiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New Mexico, New York, North Carolina, Rhode Island, South Carolina, Virginia, West Virginia, Washington, Wisconsin)
- **IMPACT** (Initiatives to Mobilize for the Prevention and Control of Tobacco)
  - Funded by the C.D.C. as a capacity-building program in a cooperative agreement arrangement with the funded states
  - States funded from 1993 – 1998
  - 32 states and the District of Columbia were funded
  - This program led directly into the National Tobacco Control Program
- **SmokeLess States**
  - Funded by the Robert Wood Johnson Foundation a competitive demonstration project
  - 48 state-wide coalitions (plus 2 additional non-state coalitions) from 1993-2004

Two observations from the above are worth noting: First, two Ontario communities participated in the COMMIT trial (Brantford and Peterborough), and second that, unlike the COMMIT and ASSIST trials, the IMPACT was not a demonstration project but rather a public health program targeting capacity building as opposed to the establishment or confirmation of new knowledge ("science"). (National Cancer Institute, 2005) It is also important to note that, while these programs were the largest and most well-known, they were by no means the first tobacco control research or programs funded by U.S. Department of Health and Human Services agencies or institutes. Rather, thousands of grant-based programs and projects had been funded, particularly by the C.D.C., N.C.I., N.H.L.B.I., and N.I.D.A., prior to onset of COMMIT, ASSIST, or IMPACT. In reality, these latter programs were the assessment (demonstration) of the effectiveness of large-scale implementation of programs and activities shown to be successful in previously funded, smaller-scale trials.

The National Tobacco Control Program (N.T.C.P.), which evolved directly from the IMPACT program, was created in 1999 and through it the C.D.C. coordinates, supports, and funds national and state-level prevention and control efforts. The N.T.C.P. identifies the following as its goals, components, and activity areas:

Goals:

1. Eliminate exposure to secondhand smoke
2. Promote quitting among adults and youth
3. Prevent initiation among youth
4. Identify and eliminate disparities among population groups

Components:

1. Population-based community interventions
2. Counter-marketing
3. Program policy/regulation
4. Surveillance and evaluation

Activity areas:

1. Clean indoor air policy
2. Tobacco use treatment
3. Access by minors
4. Advertising and promotion
5. Economic approaches (excise taxes)
6. Mass media and counter-advertising
7. Synergistic effects (changing of social norms)

From: (Centers for Disease Control and Prevention, 2010), (Wisotzky, Albuquerque, Pechacek, & Park, 2004)

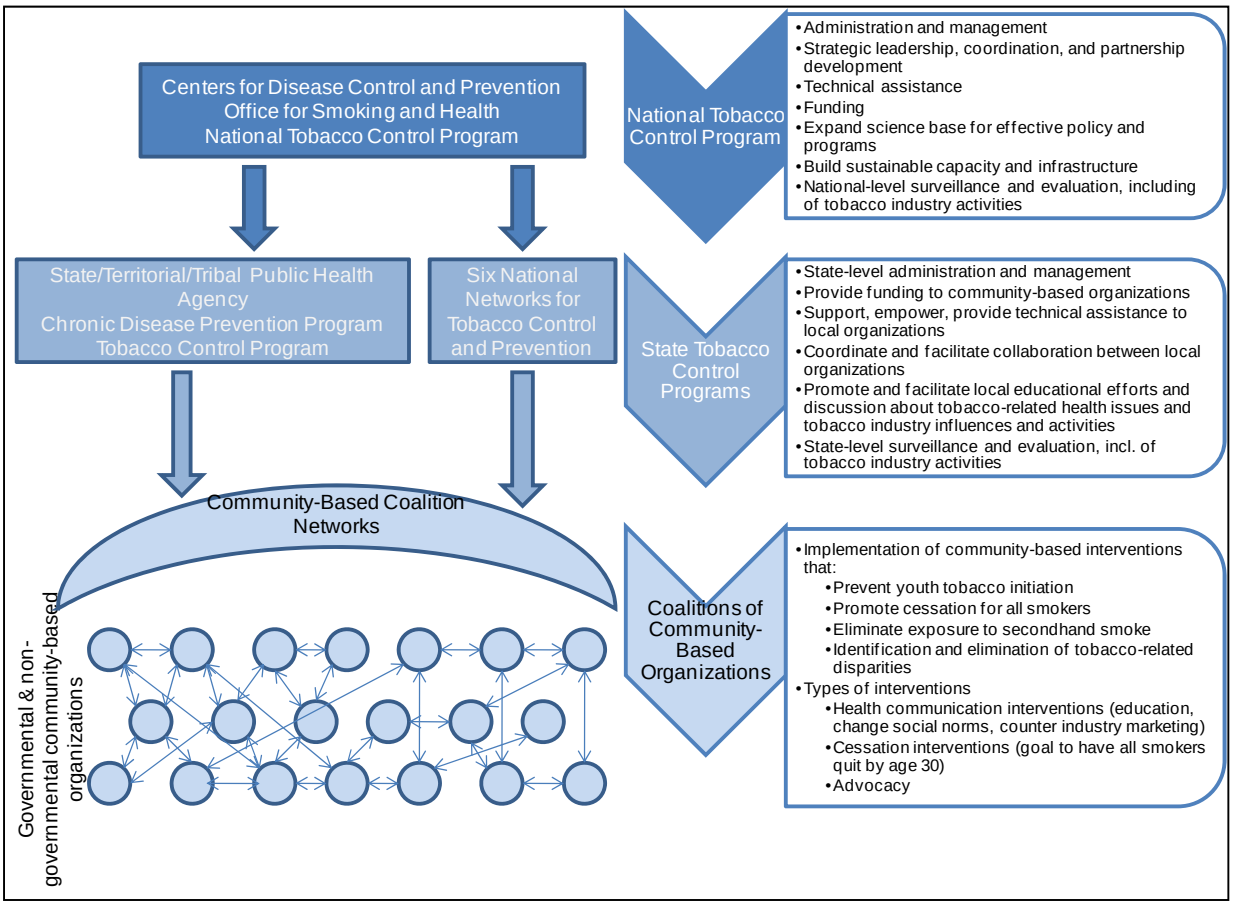
A fundamental element of the N.T.C.P. is the use of a coalition as part of the national tobacco control strategy and "best practices". The C.D.C.'s promotion of a "coalition" or "network of coalitions" model is not unique to tobacco control, but rather is the most common model used by the C.D.C. and other public health agencies (e.g., the Robert Wood Johnson Foundation) in chronic disease prevention and health promotion activities. The C.D.C. regards a coalition as a group of individuals and organizations with a diverse array of skills, expertise, resources, and spheres of influence that come together to advance a specific cause (in this case, adoption of anti-tobacco policies) and who collectively can leverage these assets to affect change in ways the members could not individually. The C.D.C. also provides support and advice on the structure, function, and sustainability of the community-based organizations and coalitions themselves. (Centers for Disease Control and Prevention, 2007) Many of these C.D.C. "best practice" strategies and approaches have been accumulated and assembled from the experiences – successful and otherwise – of the early anti-tobacco groups such as the Group Against Smoking Pollution (G.A.S.P.), the Action on Smoking and Health (A.S.H.), American Non-Smokers' Rights (A.N.R.), the collective experiences of the California anti-tobacco movement including the California Tobacco Control Program (widely considered to be pioneers in the anti-smoking campaign and the tobacco control policy movement), as well as from the formal, funded scientific trials assessing community-based approaches to implementing anti-tobacco policy trials discussed above, namely the COMMIT, ASSIST, IMPACT, and SmokeLess States programs. In addition to these public coalitions, there are myriad other groups and coalitions, variously funded by private foundations and organizations whose mission is directly and solely tobacco-related (primary) or is also but indirectly tobacco-related (secondary), that also interact with all other types of organizations, coalitions, and networks. Based on the number of agencies who have listed themselves on the Action for Smoking and Health website, it is not unreasonable to estimate that the number of groups and individuals self-identifying as an anti-tobacco coalition (or part

thereof) approaches 1,000 nationally (most states average 7-12 listed groups, but other states list many more groups – e.g., California has 69 groups and individuals listed). (Action for Smoking and Health, 2010)

Implicit within the framework of the N.T.C.P. is the utilization of this community-based coalition model to produce lasting changes in social norms for tobacco by implementing economic, regulatory, and comprehensive evidence-based programs projected to have the largest population impact. (Centers for Disease Control and Prevention, 2007) The benefits of a coalition structure are multifold. Importantly, non-governmental, community-based organizations can engage in activities, particularly policy advocacy and lobbying, not allowable by government agencies. Additional benefits of a coalition infrastructure include: representation of community diversity; synergy of resources and efforts; expansion of public support to sustain tobacco control programs; diversity in membership to propagate and amplify community mobilization; policy advocacy; changing social norms by advocating for and promoting pro-health values; membership diversity implies broad community representation and thus imparts credibility leading to community buy-in; broad and diverse coalition membership reduces duplication of effort within a community and promotes collaboration and leveraging of talents and capital, both economic and human; and more effectual efforts to counter-act tobacco industry practices. (Centers for Disease Control and Prevention, 2007) Thus, the N.T.C.P. is hierarchical in nature with the Office for Smoking and Health and the N.T.C.P. providing strategic, organizational, technical, and scientific support as well as funding to state agencies. The state agencies subsequently function similarly for the coalitions of community-based organizations. This structure, including the functions of each organization level, is depicted in Figure 1. The community-based model of coalitions thus results in overlapping networks community-based organizations that collaborate and coordinate resources to implement the N.T.C.P. recommended interventions, programs, and policies.

Funding for state-level tobacco control programs is provided from the National Center for Chronic Disease Prevention and Health Promotion at the C.D.C. to the reciprocal offices mirrored in state departments or bureaus for public health. The N.T.C.P. thus functions to coordinate and support the activities of fifty state-level tobacco prevention and control programs, as well as programs in the District of Columbia, eight other U.S. territories and jurisdictions, and seven tribal support centers. (Centers for Disease Control and Prevention, 2010) Additionally, the N.T.C.P. funds six national-level networks intended to target specific minority or at-risk communities. Currently, the funded national networks focus on African-Americans, American Indians/Alaska Natives, Asian Americans/Pacific Islanders, Hispanics/Latinos, lesbian/gay/bisexual/transgender communities, and low socioeconomic groups and include: APPEAL PROMISE Network (Asian Pacific Partners for Empowerment, Advocacy, and Leadership); National African American Tobacco Prevention Network; National Latino Tobacco Control Network; The National LGBT Tobacco Control Network; Break Free Alliance; and the National Native Commercial Tobacco Abuse Prevention Network. (National Networks for Tobacco Control and Prevention)

Figure 1. Schematic Representation of the National Tobacco Control Program



Sources: (Centers for Disease Control and Prevention, 2009), (Centers for Disease Control and Prevention, 2010), (Centers for Disease Control and Prevention, 2007), (Centers for Disease Control and Prevention, 2007)

Lastly, the smallest component of the central-level tobacco control and prevention structure is the Interagency Committee on Smoking and Health, whose predecessor was the Interagency Council on Smoking and Health. Created as part of the Comprehensive Smoking Education Act of 1984, the Committee consists of representatives from multiple agencies within the Department of Health and Human Services as well as other central-level government departments (Centers for Diseaes Control and Prevention, 2009) The Interagency Committee serves to advise the Secretary for Health and Human Services on the coordination of tobacco research and educational programs, and other tobacco-related activities with other central-, state-, and local-level government and private agencies. (Centers for Diseaes Control and Prevention, 2009) Specifically, the Committee is accountable to the Secretary for Health and Human Services through the Director of the C.D.C. and is required report biennially to Congress on educational efforts by both central-level government and private agencies to improve public knowledge about the tobacco-related health effects and the effects of such efforts (i.e., the public's level of knowledge thereof). (Centers for Disease Control and Prevention, 2007)

TOBACCO COALITIONS IN CANADA

The impetus for the development of anti-tobacco coalitions in Canada was similar to that in the United States, namely growing scientific evidence for myriad deleterious health effects attributable to tobacco use. A similar trajectory of coalition formation and activities is seen: formation of local and grass-roots anti-tobacco groups followed by the formation of nationally-focused anti-tobacco groups (and then fairly quickly by subsequent efforts to provide coordination and communication between a growing number of groups), and finally followed by formal, government action. Early Canadian actors included the Canadian Cancer Society, the Heart and Stroke Foundation of Canada, and Canadian Lung Association and their provincial counter-parts, and the Non-Smoker's Rights Association was founded in 1974 and Physicians for a Smoke-free Canada formed in 1985. (Studlar, Tobacco Control. Comparative Politics in the United States and Canada, 2002) National coordination efforts began in 1974 with the formation of the Canadian Council on Smoking or Health, now the Canadian Council for Tobacco Control. (Studlar, Tobacco Control. Comparative Politics in the United States and Canada, 2002)

The national (federal) government began to develop national tobacco control strategies in 1986. (Health Canada, 2009) The National Tobacco Control Strategy, an effort between provincial and territorial Ministers of Health and Health Canada, was renewed in 1999 and became formally coordinated through the Tobacco Control Liaison Committee, which formed in 2000. (Health Canada, 2009) The National Tobacco Control Strategy (N.T.C.S.; also the Federal Tobacco Control Strategy) includes the Tobacco Control Programme within Health Canada, which includes the Office of Policy and Strategic Planning, the Office of Programs and Knowledge Exchange, the Office of Regulations and Compliance, the Office of Research, Evaluation and Surveillance, and six regional offices. (Health Canada, 2011) The four goals and five strategic directions for the N.T.C.S. are listed as:

Four Goals:

1. Prevention: Preventing tobacco use among young people.
2. Cessation: Persuading and helping smokers to stop using tobacco products.
3. Protection: Protecting Canadians by eliminating exposure to second-hand smoke.
4. Denormalization: Educating Canadians about the marketing strategies and tactics of the tobacco industry and the effects the industry's products have on the health of Canadians in order that social attitudes are consistent with the hazardous, addictive nature of tobacco and industry products

Five Strategies:

1. Policy and Legislation: To ensure coordination of tobacco policy across sectors, and implementation of organizational policies and legislation across sectors that support reducing tobacco use.
2. Public Education: To make available and accessible information, services and programs about tobacco and tobacco related issues, which address prevention, cessation, protection and denormalization.
3. Industry Accountability and Product Control: To regulate the manufacturing, marketing, and sale of tobacco products to reduce addiction and disease.
4. Research: To increase knowledge of tobacco and tobacco use, the tobacco industry, effective interventions for tobacco control and health and socioeconomic impacts of tobacco use.

5. Building and Supporting Capacity for Action: To increase the ability of individuals, health intermediaries and communities at the national, provincial/territorial and local levels to take action.

From: (Health Canada, 2005)

The N.T.C.S. also lists explicitly the roles and responsibilities of strategy partners, which include the federal government, provincial/territorial governments, national NGOs, provincial/territorial NGOs, community and local groups, individuals, and members of the private sector. (Health Canada, 2007) Of note, while both federal and provincial governments are expected to provide leadership, resources, and support for tobacco control activities, the larger burden of administrative, support, and resources for provincial activities is the responsibility of the provincial governments. Thus, each province has its own tobacco control strategy, which mirrors the federal goals of prevention, cessation, protection, and denormalization, and coordinates and supports the activities of province-wide and local coalitions within that province. That is, provincial governments, for whom health is their jurisdiction, are responsible for the administration, implementation, coordination, and funding of tobacco control activities within the province (the exception is First Nations and Inuit tobacco control programs, which are administered through the First Nations and Inuit Branch of Health Canada). The tobacco control and coalition infrastructure in Canada includes the Steering Committee of the National Strategy to Reduce Tobacco Use (N.S.T.R.T.U.) and the Advisory Committee on Population Health (A.C.P.H.), which include members from federal, provincial/territorial, and NGO groups and coalitions.

Finally, the Canadian Tobacco Control Research Institute (C.T.C.R.I.) was founded in 1997 as a partnership with the Canadian Cancer Society, the Canadian Institutes of Health Research, the National Cancer Institute of Canada and Health Canada to "to catalyze, coordinate and sustain research that has a direct impact on programs and policies aimed at reducing tobacco abuse and nicotine addiction ". (Canadian Tobacco Control Research Institute, 2005) Funding opportunities from the C.T.C.R.I. ranged from travel and educational grants, to research planning ("seed") and policy research to larger, more programmatic ("synthesis") research projects. However, the C.T.C.R.I. was disbanded in 2009, though tobacco-related research funding remains available through the Canadian Institutes for Health Research (C.I.H.R.; the Canadian federal research agency equivalent to the National Institutes of Health (N.I.H.) in the United States) or from non-governmental organizations, such as the Canadian Cancer Society or the Heart and Stroke Foundation of Canada. (Canadian Tobacco Control Research Institute, 2005)

COMPARATIVE ANALYSIS

The similarities and differences between Canadian and American tobacco control coalitions can be examined within Donabedian's structure-process-outcome framework (Donabedian, 1966), where "structures" include the characteristics and evolution of the tobacco control coalitions, "processes" encompass the activities and strategies of the individual and collective coalitions, and "outcomes" are the important outcomes of interest discussed previously, namely comprehensive tobacco control policy implementation and reduction in tobacco use and burden.

Structures

The development and characteristics of the tobacco control coalition infrastructure in Canada and the United States are, generally, very similar. In both countries, the cumulating scientific evidence in the late 1950s and early 1960s, punctuated by a series of government reports highlighting the health consequences associated with tobacco use and culminating in the U.S. Surgeon General's Report in 1964 affirming that tobacco use caused cancer, served as focusing events that catalyzed the initial formation of anti-tobacco groups. However, it is noted that, by this time, the tobacco epidemic in both Canada and the U.S. was well entrenched: Phase IV ("Regulatory Hesitancy") in the Phases of Tobacco Control Model or Phase II of the Tobacco Epidemic Model, discussed above. The proliferation of local, state and provincial, and national groups, along with increasing focus from non-governmental agencies, prompted both the Canadian and U.S. governments to develop "clearinghouse" and "coordination" type infrastructures at the national level. This was a natural extension for both Canadian and American public health officials, as tobacco as a "health problem" was clearly already part of the respective agencies public health agendas for their countries (the respective public health agencies in each country had already published scientific / policy reports about the deleterious health consequences of tobacco use).

As regards the current coalition infrastructure in each country, again there are many similarities. The federal (central) government has a leadership and scientific role, with the provinces and states having a leadership role within each of their own jurisdictions. Communication and coordination amongst, between, and within groups and coalitions is encouraged and fostered. Further, both countries developed and implemented their national tobacco control strategies in a very similar timeframe – the late 1990s – though, again, not until after further advancement of the tobacco epidemic into the 5th phase of the Phases of Tobacco Control Model or the 3rd stage of the Tobacco Epidemic Model, discussed above. Some differences, however, can be seen. In the U.S., there is a stronger, more institutionalized link to county-level health departments and their inclusion as both a focal point for local action as well as their membership in state-wide coalitions. While local, community-based groups are a component of the Canadian N.S.T.R.T.U., their role as the foundation for local, municipal action is not as explicit as it is for their American, county-level counterparts. These subtle structural differences at the local level may be interpreted as differences in Canadian compared to American federalism. Or, a more complete network of robust county-level governments may simply reflect a necessity born of a larger populace and a practical need for a more comprehensive "third level" of government in the United States.

An additional, important difference has been the more comprehensive role played by the C.D.C. compared to Health Canada. The C.D.C., in conjunction with other governmental medical science research agencies within the N.I.H., used their existing peer-review grant-making mechanisms to develop both biomedical as well as public health knowledge. While biomedical research project focused on uncovering the mechanisms underlying the physiologic consequences of tobacco use, public health focused projects on developing and testing effective population-based programs and interventions to reduce tobacco use and, ultimately, the tobacco burden. The biggest large-scale, multi-site trials, in which Canadian communities participated, were initiated, coordinated and funded by American-based agencies, in particular the N.C.I., and non-governmental organizations, in particular the R.W.J.F. Additionally, the C.D.C.,

in the early 1990s, was using its existing capacity for non-competitive, cooperative funding arrangements and national network of chronic disease prevention programs housed in state bureaus for public health to develop capacity and infrastructure to implement local, community-based tobacco control activities (i.e., the IMPACT program).

This difference in evolution and origins highlights another important difference between the two countries: the C.D.C. was and remains more active in the development of the national-to-local / local-to-national coalition infrastructure, particularly as regards funding. Specifically, the C.D.C. has and provides direct programmatic funding (in addition to ongoing, competitive, peer-reviewed grant-based funding) to state and, subsequently, local coalitions. These monies may or may not be then additionally supplemented by monies from state and / or other non-governmental organizations. In Canada, however, federal funding streams are less formalized, often flow directly to non-governmental organizations (which, in the Untied States, are much more likely to rely upon their own funding sources), and there is a much stronger emphasis on the provinces, particularly as regards funding. The C.D.C. also appears to be more active in leading the direction of programmatic activities in the United States, compared to Health Canada. There are multiple possible explanations for this seemingly more active role by the C.D.C. One possible interpretation is, as an organization that was at the forefront of supporting the development of the evidence base for effective community and population tobacco control programs and policies, the C.D.C. has a larger investment and thus ownership over the implementation of the knowledge and programs for whose development they were responsible. A second set of explanations are predicated on the structural differences between Canada and the United States. In contrast to the United States, where health is a shared and overlapping responsibility between the federal, state, and county governments, in Canada, health is a decidedly provincial activity reflected and reinforced in, most obviously, the Canada Health Act. Thus, stronger role for the provinces, including in the funding of tobacco control activities, represents a differential form of historic institutionalism in the two countries. These differences may also be interpreted as differences in the federalist forms between the two countries. As others have previously forwarded, the more prominent, almost “activist”, role for the C.D.C. compared to Health Canada is consistent with a more regulatory vs. permissive form of federalism in the United States compared to Canada (Kelemen, 2000), or a tendency toward a more multi-level governance form of federalism in Canada compared to the United States. (Studlar, What explains the paradox of tobacco control policy under federalism in the U.S. and Canada? Comparative federalism theory vs. multi-level governance, 2010)

Processes

In both countries, a coalition network structure has emerged as the approach to affect the dual outcomes of implementing comprehensive tobacco control policy and reducing the societal tobacco burden. Additionally, the general goals of the national strategies, including identified priorities for programmatic activities, are remarkably similar, though Canada does generally have a somewhat more explicit emphasis on denormalization. For both countries, the activities and programs are also consistent with the general international consensus on tobacco control best practices, for example the foundation for the Framework Convention for Tobacco Control and the MPOWER package. (World Health Organization, 2008) The rationale for the adoption of a coalition approach, by Canada, the United States, or the international community, is not clear. That is, whether a “bottom-up” approach was adopted as means of venue

shopping in the face of central resistance, or as a means to simultaneously facilitate both local and central activity – a "sandwich" approach – and the comparative effectiveness of the different approaches, is likely an untestable hypothesis and will remain in the realm of interpretation and speculation.

However, beyond an inventory of which programmatic activities are / have been conducted, little systematic detailed knowledge is available from coalitions in either Canada or the United Stated regarding the finer points of program implementation, tactics, and activities within the "three spheres" – scientific (disseminating scientific "truths", dispelling scientific "myths", and bringing this knowledge to bear on tobacco use and policy), social (denormalisation of tobacco use), or political (the representation of public health interests in policy subsystems). Neither is information available about the comparative effectiveness in achieving either intermediate or long-term outcomes of these activities and tactics. While statistical techniques such as network analysis are now being applied to the evaluation of the organizational characteristics of state-level tobacco control programs and networks of the associated community-based coalitions (Krauss, Meuller, & Luke, 2004), (Harris, Luke, Burke, & Meuller, 2008) these analyses and the results from them are still nascent. Thus, substantial scholarship remains to develop more rigorous assessment methodologies for these coalition networks so as to elucidate the most effective program structures and processes to elicit the best scientific, social, and political impact, thus best influencing the desired outcomes of comprehensive tobacco control policy adoption and reduction of the societal tobacco burden.

Outcomes – Tobacco Control Policies

As has been previously characterized (Studlar, Tobacco Control. Comparative Politics in the United States and Canada, 2002), tobacco control policies in Canada and the United States, at least at the federal (central) level have been characterized by leapfrogging as well as convergence, both across the border as well as within each country between the federal (central) and provincial / state or local (municipal / county) governments. After the initial series of government reports affirming a causal link between tobacco use and cancer, the United States quickly enacted federal legislation (the Federal Cigarette Labeling and Advertising Act of 1965 and the Public Health Cigarette Smoking Act of 1969) but it was not until 1984 that the U.S. Federal government again enacted tobacco control legislation. In Canada, in contrast, there was a 1971 voluntary agreement with the tobacco industry to end radio and TV advertising, but it was not until 1988 that comprehensive tobacco control legislation (other than taxation) was enacted in Ottawa (the Tobacco Products Control Act of 1988, though certain provisions of this Act were struck down by the courts). Rather, the period from the late 1960s – the late 1980s represents the period of "Regulatory Hesitancy" (Phase IV or the Phases of Tobacco Control Model, discussed above) at the central level in both countries. This time period, as has been highlighted above, was instead a period of focus on the development of coalitions and networks at the state / provincial and local (municipal / county and "grass roots") levels with coordination, capacity-building, and the development of evidence for evidence-based policy supported by the federal health agencies, the latter particularly the case in the U.S. In both countries the 1990s and 2000s saw multiple attempts in multiple venues (central/federal, provincial/county and local governments, and frequently the courts) to arrive at the current key policy outcomes – the legislation comprising the tobacco control policy regimes at the federal (central) level.

In Canada, the current tobacco control policy at the central level is the Tobacco Act of 1997. The key provisions of this Act are summarized in Table 4. In the United States, the struggle to have the F.D.A. regulate tobacco products, beginning with the ill-fated 1996 F.D.A. Final Rule, was finally achieved with the Family Smoking Prevention and Tobacco Control Act of 2009. Key provisions of this Act are summarized in Table 5. Key similarities are patent: the central level legislation in both countries addresses product content and standards, advertising and promotion, package labeling, and youth access. Taxation at the central level is addressed separately and issues such as "clean air" are within the jurisdiction of the provinces / states or appropriate local governments. The U.S. Family Smoking Prevention and Tobacco Control Act of 2009, while clearly longer (a decade) in the making, is more comprehensive than the 1997 Canadian Tobacco Control Act, including several additional key provisions such as the regulation of new products. It also employs a very different strategy: the U.S. Act creates a much stronger bureaucratic infrastructure within the F.D.A. and provides rather substantial regulatory leeway for the F.D.A. to implement and enforce the Act. That is, the Family Smoking Prevention and Tobacco Control Act of 2009 functionally moves substantial portions of tobacco policy into the executive branch of the American government, removing it from the legislative branch and the necessity to achieve compromise – notoriously difficult in the U.S. system – in that branch. In contrast, the Canadian Tobacco Control Act is much more prescriptive, does not provide for an equivalent bureaucratic infrastructure, and requires re-approval of the House of Commons for new regulations pursuant to multiple Sections of the Act. This is a somewhat ironic reversal of the "regulatory" vs. "permissive" forms of federalism often discussed in the United States vs. Canada. (Kelemen, 2000), (Studlar, What explains the paradox of tobacco control policy under federalism in the U.S. and Canada? Comparative federalism theory vs. multi-level governance, 2010) While whether the new regime in the United States is a result of the decades-long capacity-building efforts and local, bottom-up approaches is not a testable hypothesis (there is no "control), no doubt this new policy-induced structural difference between Canada and the U.S. will be closely followed and studied on both sides of the border to understand, over time, the marginal impacts on the population burden of tobacco use.

Table 4. Key Provisions of the Canadian Tobacco Control Act of 1997

Topic	Description
Standards for Tobacco Products	• Specifies a list of specifically prohibited additives for tobacco products • Manufacturers must submit product contents and research to the Minister • The Minister may make regulations prescribing the allowable amounts of ingredients in the product or emissions
Access to Tobacco Products by Young People	• Prohibits sales to youth • Packages must contain at least 20 units (i.e., no "mini" or "sampler" sales) • Limits on tobacco sales in vending machines • Prohibits direct order (mail) sales •
Labeling	• Requires warning labels on all products
Promotion	• Prohibits false promotion, "testimonials", and "life-style" advertising, event or venue sponsorship • Restricts point-of-sale displays
Enforcement	• Allows the Minister to appoint personnel for the purpose of enforcement
Regulations	• The Minister may enact some regulation but also proscribes that regulations for certain sections within the Act require without subsequent approval of the House of Commons

1Source: Tobacco Control Act of 1997

Table 5. Key Provisions of the U.S. Family Smoking Prevention and Tobacco Control Act of 2009

Topic	Description
Allowable Scope of Activity	Secretary/FDA may: • Restrict sale or distribution of products to protect public health • Restrict advertising and promotion consistent with the First Amendment • Alter label requirements to promote better understanding of risk of use of tobacco products • Adopt product standards that reduce the yield of nicotine and reduce or eliminate other product components • Conduct product testing • Can recall or ban a product that poses unreasonable risk of substantial harm
Disallowed Scope of Activity	Secretary/FDA may not: • Ban cigarettes/tobacco products • Require reduction of nicotine content to zero • Require written or oral prescription to obtain products • Prohibit face-to-face sales in retail outlets • Establish a minimum purchase age older than 18 years • Publicly disclose trade secrets or other confidential information
Infrastructure	Secretary/FDA must create: • Center for Tobacco Products to implement Act • Technical support office for small manufacturers • Tobacco Products Scientific Advisory Committee • Expert Panel
Preemption	• Federal agencies, states, political subdivisions, Indian tribes etc., may enact additional or stricter measures, including excise taxes, except for those relating to product manufacturing standards, adulteration and labeling, and modified risk tobacco products • States and localities can impose specific bans on the time, place, or manner of advertising or promotion but not the content of such advertisements
Product and Manufacturing Standards	Requires that tobacco manufacturers: • Submit a list of ingredients (and quantity) for each product • Submit the form and content of nicotine in each product • Submit a list of "harmful constituents" (as defined by the Secretary/FDA) in each product • Submit all documents that relate to health, toxicologic, physiologic, or behavioral effects of tobacco products, additives, or components • Register annually with the Secretary/FDA • Comply with manufacturing standards, including uniform standard for ingredients, to be established by the Secretary/FDA • Foreign/tobacco importers must register with the Secretary/FDA and reasonably comply with requirements to establish that product content and manufacture conform with standards to be set by the Secretary/FDA
New Products	• Pre-market approval for all new products • The Secretary/FDA must develop a pre-market approval process that includes health information
Amendment of Previous Acts	• Amends the Federal Cigarette Labeling and Advertising Act such that labeling requirements are those developed by the Secretary/FDA • Amends the Comprehensive Smokeless Tobacco Health Act of 1986 such that labeling requirements for smokeless tobacco products are the same as those developed by the Secretary/FDA for cigarettes
Re-issue of 1996 FDA Final Rule	The Secretary/FDA is required to re-issue the Final Rule as issued by the FDA in 1996 with some minor revisions. The rule requires: • Ban on sales of tobacco products to those <18 years of age • Ban on packs with <20 cigarettes • Significant limitations on sales from vending machines or self-service displays • Bans free samples of cigarettes; limits distribution of smokeless tobacco • Bans brand-name sponsorship for sporting, musical, or cultural events or sponsorship of any team or group participating therein • Bans gifts of cigarettes/tobacco products or gifts for buying cigarettes/tobacco products • Bans use of music in audio ads (i.e., words only) • Bans sale or distribution of branded non-tobacco products (e.g., hats, t-shirts) • Restricts advertising, bans outdoor advertising within 1000 feet of schools
Modified Risk Tobacco Products	• A modified risk product may be commercially marketed if: 1) it significantly reduces tobacco-related harm for tobacco users; and 2) have population benefits for both smokers and non-smokers when evaluated as actually used by consumers • A product not labeled or marketed as a modified risk product may be sold for five years if: 1) it would promote public health; and 2) the product is expected to benefit the health of the population • Post-market surveillance is to be conducted on all reduced risk products with reports annually
Specific Requirements -- Additives	• All flavorings, natural or artificial, such as vanilla, clove, orange etc., are banned with the exception of menthol
Required Action – Further Study Mandated	• Expert Panel shall study health implications of raising minimum age to purchase tobacco products • Tobacco Products Scientific Advisory Committee shall study and report on: 1) the effects of altering nicotine content including whether there is a point at which dependence / addiction is not induced; 2) the health impact on the use of menthol; 3) the nature and health impact of dissolvable tobacco products
Required Action – Public Disclosure	• The Secretary/FDA must publish annually a list of harmful or potentially harmful products in each tobacco product
Miscellaneous Stipulations	• Tobacco manufacturers may not in any way use FDA regulation to construe that tobacco products are safe • Secretary/FDA required to issue regulations mandating use of color graphic health warning labels

Source: (Congressional Research Service, 2009)

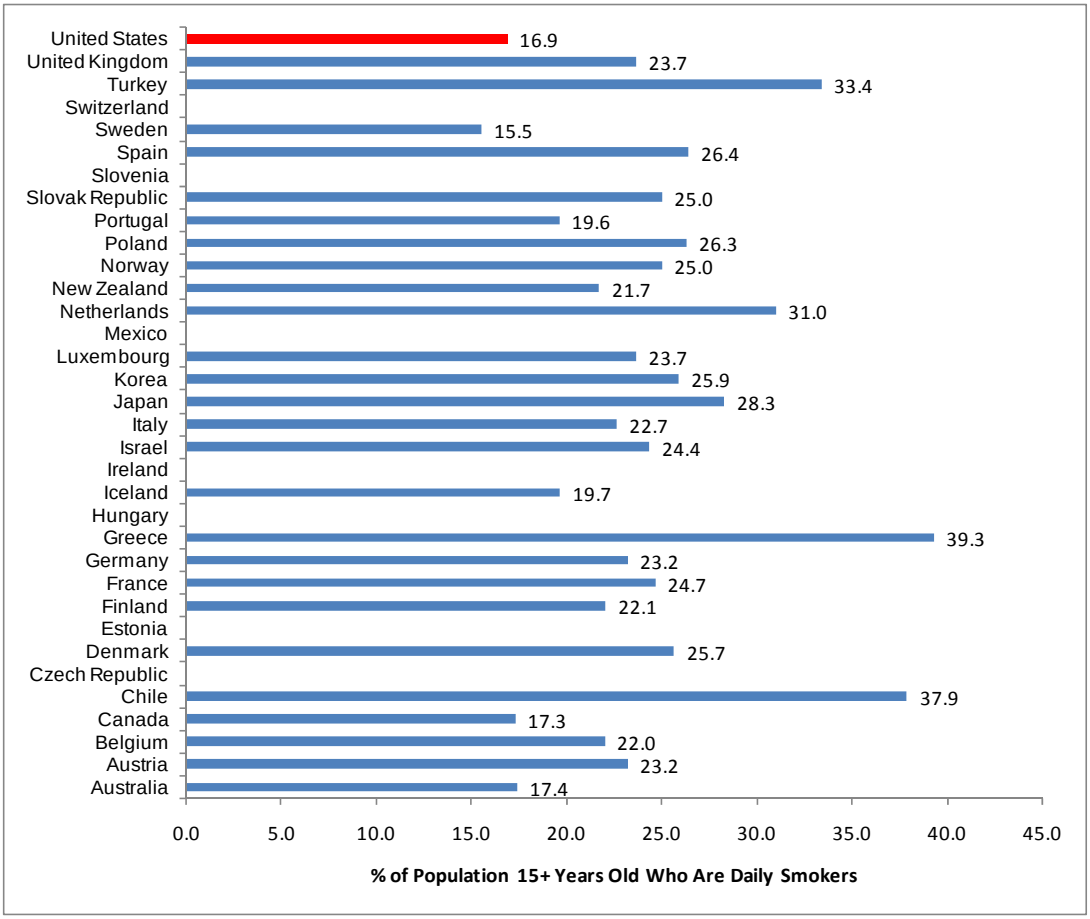
As regards taxation, Canada has typically exceeded, both in time and amount, taxation increases and levels compared to the U.S. In the United States, as part of Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 (Public Law No. 111-3), the central-level tobacco excise tax was raised to $1.01, a $0.62 increase from the

previous excise tax of $0.39. The excise-tax increase was included as a revenue provision of the bill, meaning that the excise tax was "paying for" the CHIP reauthorization and program expansion. Per the provisions in the Bill, the excise tax covers cigars, cigarettes, cigarette papers and tubes, smokeless tobacco, pipe tobacco, roll-your-own tobacco, and also taxes floor stocks of tobacco products. The Bill, and tax increase, was effective April 1, 2009. Combined with the most recent information on state excise taxes (Centers for Disease Control and Prevention, 2010), which in 2009 averaged $1.37 per pack, the "average" combined federal and state excise tax for cigarettes in the United States is $2.38. As a comparison, in 2009 the Canadian federal excise tax for cigarettes was CDN$1.70 per pack and an average provincial excise tax of CDN$3.43, resulting an "average" combined federal and provincial excise tax of CDN$5.13 per pack. (Tran, 2009)

Outcomes –Population Tobacco Burden

For all intents and purposes, tobacco use on both sides of the border is identical. As demonstrated in Figure X, both Canada and the United States have amongst the lowest smoking rates in developed countries, out-performed only by Sweden. That is, efforts on both sides of the border, with both their similarities and differences, have resulted in the same level of population tobacco burden.

Figure 1-1. Smoking Prevalence in OECD Countries, 2004-2006



Data Source: OECD Heatlh Statistics, 2010

DIRECTIONS FOR FUTURE RESEARCH

This work has posited that the now ubiquitous tobacco control coalition and coalition infrastructure has been developed to simultaneously address each of the "three spheres" of the tobacco control challenge – scientific, social, and political –in a diverse polity to affect the important outcomes of interest, namely comprehensive tobacco control policy implementation and reduction in tobacco use and burden. The comparative evolution and present structures of tobacco control coalitions in Canada and the United States have been compared. While many similarities exist, several differences have been noted, particularly the more prominent role for "science" and scientific mechanisms in the U.S. to develop both scientific evidence and capacity, as well as a new paradigm for tobacco regulation within the F.D.A. in the United States. However, very little is understood about the "processes" in which these coalitions and coalition networks engage. In particular, much scholarly activity is still needed to better understand the tactics and approaches used by these coalitions – and the relative effectiveness of such activities – in the scientific (disseminating scientific "truths", dispelling scientific "myths", and bringing this knowledge to bear on tobacco use and policy), social (denormalisation of tobacco use), or political (the representation of public health interests in policy subsystems) spheres and, in turn, these activities affect comprehensive tobacco control policy implementation and reduction in tobacco use and burden. The importance of understanding these dimensions is not lost in light of the growing public health burden of conditions such as diabetes and obesity, which also have substantial social-behavioral component: lessons about the comparative effectiveness from tobacco control coalitions can be applied to these and other emerging public health challenges.

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